REPORT TO THE

TWENTY-THIRD LEGISLATURE

STATE OF HAWAII

2006

PURSUANT TO
SECTION 329-3, HAWAII REVISED STATUTES,
REQUIRING A REPORT BY THE
HAWAII ADVISORY COMMISSION ON DRUG ABUSE
AND CONTROLLED SUBSTANCES
(HACDACS)

PREPARED BY:

HAWAII ADVISORY COMMISSION ON DRUG ABUSE
AND CONTROLLED SUBSTANCES

DEPARTMENT OF HEALTH
STATE OF HAWAII
JANUARY 2006

EXECUTIVE SUMMARY

Fiscal Year 2004-05 Annual Report for the Hawaii Advisory Commission on Drug Abuse and Controlled Substances (HACDACS) is submitted pursuant to Section 329-3, Hawaii Revised Statutes (HRS).

Duties of the Hawaii Advisory Commission on Drug Abuse and Controlled Substances are delineated in Section 329-4, HRS. The commission adopted the following as its mission statement:

> The mission of HACDACS is to contribute to the solution of problems arising from substance abuse by acting in an advisory capacity to the Governor and the Legislature, and to the Departments of Health and Public Safety.

Pursuant to Section 329-2, HRS, the 15 commission members "... represent the pharmacological, medical, community and business affairs, youth action, educational, legal defense, enforcement, and corrections segments of the community."

Fiscal Year 2004-05 Annual Report for the commission contains information on its membership, organizational structure and highlights of activities.

RECOMMENDATIONS

Based on deliberations, as well as presentations throughout the past year, HACDACS recommendations to address the issue of substance abuse are as follows:

HACDACS recommends focusing on communities' needs to reduce the impact of illicit drug use and underage drinking.

HACDACS recommends supporting and empowering communities to address illicit drug use and underage drinking.

HACDACS recommends supporting efforts that ensure accountability throughout the substance abuse prevention and treatment systems to ensure that public funds are utilized effectively.

HACDACS recommends expanding coordination between agencies and organizations to include collaboration that encourages community participation.

HACDACS recommends creating an integrated data infrastructure to inform decision-making, prioritizing of services and resource allocation.

HACDACS recommends reducing underage drinking through partnerships between organizations and public agencies to coordinate new and innovative strategies.

HACDACS recommends enhancing the continuum of care that supports the continuum of care, including outreach, stabilization, as well as relapse prevention services.

REPORT TO THE LEGISLATURE
SUBMITTED BY
THE HAWAII ADVISORY COMMISSION ON DRUG ABUSE
AND CONTROLLED SUBSTANCES (HACDACS)
FOR FISCAL YEAR 2004-05

Duties of the Hawaii Advisory Commission on Drug Abuse and Controlled Substances (HACDACS) are delineated in §329-4, Hawaii Revised Statutes (HRS). The commission adopted the following as its mission statement:

> The mission of HACDACS is to contribute to the solution of problems arising from substance abuse by acting in an advisory capacity to the Governor and the Legislature, and to the Departments of Health and Public Safety.

Pursuant to Section 329-2, HRS, the 15 commission members are "selected on the basis of their ability to contribute to the solution of problems arising from the abuse of controlled substances, and to the extent possible, shall represent the pharmacological, medical, community and business affairs, youth action, educational, legal defense, enforcement, and corrections segments of the community." The commission is attached to the Department of Health for administrative purposes.

MEMBERS BY CATEGORY OF APPOINTMENT AND TERM OF OFFICE*

JUDITH AKAMINE
(East Hawaii) - Community and Business Affairs - 6/30/06

GARY L. BLAICH, M.D.
(Kauai) - Medical - 6/30/07

LANI L. BOWMAN
(West Hawaii) – Community and Business Affairs - interim

THE REVEREND ALISON M. DINGLEY
Community and Business Affairs - interim

KRISTINE M. FOSTER
Community and Business Affairs – 5/5/05

KEVIN M.F. HO, Pharm. D.
Pharmacology - interim

BART S. HUBER
Enforcement - interim

T. VIVIAN ISHIMARU-TSENG, M.D.
Medical - interim

BARBARA-ANN KELLER
Youth Action - 6/30/05

MITCHELL "MITCH" KEPA
(Maui) Education - interim

CHAD Y. KOYANAGI, M.D.
Medical - interim

WENDELL T. MURAKAWA
Corrections - 5/5/05

THELMA C. NIP
Education - 6/30/05

BARBARA A. YAMASHITA
Community and Business Affairs - 5/5/05

VACANT

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* Terms of the following members were extended pursuant to §26-34(b), HRS: Lani L. Bowman, Alison M. Dingley, Kevin M.F. Ho, Bart S. Huber, T. Vivian Ishimaru-Tseng, Mitchell Kepa, and Chad Y. Koyanagi.

TOPICS DISCUSSED

During Fiscal Year 2004-05, members heard presentations by service providers as well as agency representatives on a wide array of topics. Members were also briefed on the following reports and research initiatives:

Unannounced Inspections of Alcohol Retail Outlets and Related Enforcement Activities. The "Underage Alcohol Sales Survey" project was conducted by MADD Hawaii, Inc. (Mothers Against Drunk Driving) and Mattson Sunderland Research and Planning Associates, Inc. for the Alcohol and Drug Abuse Division of the Hawaii State Department of Health. The study was done in cooperation with the County Liquor Commissions and the County Police Departments. The project's ultimate aim is to reduce underage persons' ("youths") access to alcohol, because it is illegal to sell alcoholic beverages to persons under 21 years of age in Hawaii.

A sample of 571 outlets were randomly selected on statewide (373 on Oahu, 54 on Hawaii, 87 on Maui and 57 on Kauai). Of these 495 were surveyed to determine the rate of alcohol sales to underage youth in retail stores in the state (317 on Oahu, 53 on the Big Island, 74 on Maui and 51 on Kauai). If a sale was made, a police officer (a liquor commissioner on Hawaii) was on hand to issue a citation for the violation or a warning in the case of the Big Island. The remaining 76 outlets were either "located and not attempted (a special circumstance), "closed at the time of attempt, "out of business (2) " or "not located." The project involved sending a team of "inspectors" consisting of a representative of MADD, a police officer, and a youth to designated stores and having the youth attempt to purchase alcohol. Youths ages 19 or 20 served as "decoys" in attempting to purchase alcohol at each location. After making a purchase attempt and leaving the store, the youth completed a data collection form.

Key findings.

> Oahu had the highest percentage of successful purchase attempts (18%), followed by Maui (11%) and Kauai (10%). The Big Island experienced the lowest percentage of successful purchase attempts (6%).
>
> As a general rule, the large majority of successful buyers were asked for their ID and then sold the item anyway.
>
> The large majority of outlets had signs advertising alcohol and at least three-quarters of the outlets featured signs saying "We card." With the exception of Maui County, very few outlets had signs promoting the "Six Step ID" program.
>
> At least nine out of ten sellers asked for an ID and fewer then 20% asked age (except Maui County where 47% asked age).
>
> Maui County had the highest percentage of cash registers enabled to calculate age (57%), followed by Kauai (37%), Hawaii (22%) and Oahu (18%).

Purchases were more likely occurred at a convenience store, followed by a gas station (except Oahu). The seller was more likely female and signs were not a deterrent. Outlets equipped with "age enabled" cash registers were unlikely to make a sale.

Conclusions and recommendations.

The survey found the rate of retail alcohol sales to underage persons range from 18% on Oahu to 6% on the Big Island. These rates represent an unacceptable level of alcohol sales to underage persons and a problem regarding youth access to alcohol products throughout the Hawaii. Continued efforts should be made to increase awareness among vendors and the public.

Conducting alcohol purchase surveys continues to play an important role in finding out who sells to minors and how often, raising community awareness and building support for education and enforcement efforts, educating merchants, and measuring the effectiveness of strategies for combating sales to underage youth.

Hawaii tobacco sales to minors among lowest in the nation. A survey by the Hawaii State Department of Health's (DOH), Alcohol and Drug Abuse Division (ADAD), shows sales of tobacco to minors in Hawaii decreased, compared to last year. The survey is a joint effort between DOH and the University of Hawaii's Cancer Research Center of Hawaii.

In the Spring of 2004, teams made up of youth volunteers (ages 15-17) and adult observers visited a random sample of 211 stores in which the youth attempted to buy cigarettes to determine how well retailers were complying with the State tobacco laws.

Eleven stores (5.2%) sold to minors (ages 15-17) without identification. Since this annual survey started in 1996, the rates of noncompliance have dropped from 44.5% (1996) to 6.2% in 2003 and finally to 5.2% this year.

The significant factors associated with purchase of tobacco during 2004 annual inspections were:

Type of outlet. Gas stations and gas convenience stores were more likely to sell to minors (14.0% compared to 6.6% for grocery, food, restaurant and liquor stores).
Whether the clerk requested identification. 50% of clerks who did not ask the minor for identification sold tobacco to minors.
Whether the clerk requested identification or age. If clerks did not ask for age or identification, they were ten times more likely to sell to minors.
Gender of minor. Clerks were more likely to sell to male minors (19.1%) than to female minors (1.8%).
Age of minor. Clerks sold to minors 15 years old more frequently (15.4%) than to minors age 16 (2.8%) or age 17 (9.4%).

Hawaii State Law prohibits tobacco sales to persons under the age of 18. Merchants convicted of selling to minors face a mandatory fine of $500.

The DOH provides information and training to educate store clerks to help them identify minors and develop skills to prevent sales to those under the age of 18. Newly developed outreach materials help clerks know which years on identification documents they can sell tobacco products to. Statewide compliance inspections, in partnership with the Cancer Research Center and the County Police Departments, will continue to be conducted.

In 2003, Hawaii ranked fourth among the most successful states with only Delaware, Colorado and Louisiana producing better results. Hawaii has a comprehensive tobacco prevention strategy with an aggressive, engaging media campaign, extensive merchant education, and a print campaign that recognizes local merchants who complied and did not comply with the illegal sales to minors law.

The Synar Regulation, a federal mandate, requires each state to document a rate of tobacco sales to minors of no more than 20% or risk losing millions in federal funds for alcohol and other drug abuse prevention and treatment services.

The Hawaii Year 2004 survey found that 5.2% of the stores inspected, in the scientifically-based random sample of retail outlets throughout the State, sold cigarettes to minors. The 2004 non-compliance rate for the City and County of Honolulu is 6.3%. Hawaii and Kauai County rates of sales are 0.0%, while the Maui County rate is 6.9%.

In addition to the Synar Regulation inspections, the DOH, in cooperation with all four County Police Departments and the Cancer Research Center of Hawaii, has a program to enforce the State statute. Every outlet in the State that sells tobacco is inspected at least once a year, and often twice. The enforcement program uses teenagers between the ages of 15 and 17, carrying identification, who attempt to purchase cigarettes under the supervision of an undercover police officer.

There were 1,136 retail outlets throughout the State of Hawaii inspected from April 1, 2003 to March 31, 2004. 15.9% of the outlets (180 stores) sold to minors (ages 15-17) who produced valid identification if asked for it. This is a slight increase from last year's noncompliance rate of 13.9% (2003). Results of these operations were published monthly in all county newspapers.

Police stings on tobacco sales to minors breakdown, by county over the years:

COUNTY	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**# stores inspected 2004**
Honolulu	18.1%	23.2%	15.6%	27.3%	24.7%	16.7%	13.8%	14.8%	590
Hawaii	N.A.	43.1%	16.2%	21.4%	30.6%	27.3%	20.6%	18.8%	271
Kauai	N.A.	20.7%	7.8%	N.A.%	27.6%	12.7%	9.6%	11.1%	108
Maui	N.A.	8.7%	19.7%	28.4%	26.5%	15.2%	11.5%	18.0%	167
State of Hawaii	N.A.	22.4%	15.2%	27.0%	26.1%	17.6%	13.9%	15.9%	1,136
(Notes: The data for 1997 only includes the County of Honolulu. The increase from 1999 to 2000 may be due to a change in methodology. Prior to 2000, minors were not required to carry identification.)									

2003 Hawaii Student Survey. Findings of the survey of Hawaii 6th – 12th graders were released in early January 2005. Preliminary findings show that: girls are using more than boys; "ice" use among adolescents and teens is low; and students meeting the Diagnostic and Statistics Manual (DSM) criteria; rates for drug use have declined for all drugs and this is reflected in rates for treatment need (1998 – 16%; 2000 – 13.4%; 2002 – 10.6%; 2003 – 6.9%) although rates for Ecstasy are high.

Estimated Treatment Needs Continue to Decline – More Students in Need are Reporting They Have Utilized a Treatment Program. Hawaii adolescent treatment needs are assessed by applying the DSM-III-R criteria, which include assessment of physiological symptoms, such as tolerance and withdrawal; behavioral symptoms, such as impaired control over the use of substances; and substance use in dangerous situations. Statewide treatment needs for alcohol and/or drug abuse increased drastically from 1996 (10%) to 1998 (16%), but dropped in 2000 (13%), 2002 (11%), and again in 2003 (7%).

In 2003, Hawaii treatment needs among public and private school students in grades 6 through 12 are as follows: 2,500 students for alcohol abuse only; 1,961 students for drug abuse only; 3,373 for both alcohol and drug abuse; and 7,826 students for any substance abuse.

2003 ESTIMATED NEED FOR ADOLESCENT (GRADES 6-12) ALCOHOL AND DRUG ABUSE TREATMENT IN HAWAII∗

COUNTY/DISTRICT INFORMATION		Need Treatment for Alcohol Abuse		Need Treatment for Drug Abuse		Need Treatment for Both Alcohol and Drug Abuse		TOTAL TREATMENT NEEDS	
	Total N	%	n	%	n	%	N	%	n
HONOLULU	61,096	2.0%	1,203	1.8%	1,073	2.4%	1,493	6.2%	3,759
Honolulu District	16,542	1.7%	289	1.4%	238	2.3%	378	5.5%	902
Central District	16,046	1.8%	291	2.0%	324	1.9%	309	5.7%	922
Leeward District	19,921	2.0%	399	1.7%	347	2.3%	467	6.1%	1,208
Windward District	8,587	2.6%	224	1.9%	164	4.0%	339	8.5%	727
Hawaii County/District	12,734	3.5%	450	2.2%	275	4.7%	602	10.4%	1,330
Kauai County/District	5,632	1.6%	88	1.9%	104	3.5%	199	7.0%	392
Maui County/District	10,976	3.0%	326	2.7%	301	3.8%	419	9.5%	1,044
All Public Schools	90,438	2.3%	2,067	1.9%	1,753	3.0%	2,713	7.2%	6,525
Private Schools	22,871	1.9%	433	0.9%	208	2.9%	660	5.7%	1,301
TOTAL STATEWIDE	113,309	2.2%	2,500	1.7%	1,961	3.0%	3,373	6.9%	7,826

At the county level, Hawaii and Maui Counties have the greatest proportion of students in grades 6 through 12 needing treatment (10% each), followed by Kauai County (7%) and the City & County of Honolulu (6%). The City & County of Honolulu, however, has the largest number of students in grades 6 through 12 estimated to need treatment (3,759), followed by Hawaii (1,330),

∗ The report is located at: http://www.hawaii.gov/health/substance-abuse/prevention-treatment/survey

Maui (1,044), and Kauai Counties (392). At the district level, Windward District exceeds other districts on Oahu in regards to treatment needs (9%); other districts on Oahu have treatment needs estimated at 6%.

In 2003, nearly twice as many students diagnosed as needing treatment are reporting they have utilized a treatment facility than in previous years. Of the students with treatment needs, 23% of the 6th graders, 25% of the 8th graders, 18% of the 10th graders, and 15% of the 12th graders reported they received help from a treatment program during the past year.

Conclusion. The results of the study show that substance use is on the decline, but continues to be a significant problem affecting the youth of Hawaii. By the time students become seniors nearly half have tried an illicit drug (47%) or cigarettes (45%), and nearly three quarters (73%) have tried alcohol. At least 1 out 20 seniors has tried an illicit drug other than marijuana. In the middle schools, over one third of the 8th graders have tried alcohol (37%), nearly one fourth have tried cigarettes (23%), and at least one tenth have tried marijuana (12%).

Although the findings from the current study illustrate that substance use is clearly on the decline in Hawaii, we are nowhere near the point of being able to stop the war on drugs. Many of the illicit drugs have been on the decline for a number of years in Hawaii, only to be replaced in popularity at various points in time by new drugs. For instance, while other illicit drugs declined in 2000 and 2002, reports of ecstasy use continued to rise until 2003. In 2003, prevalence reports for ecstasy finally dropped, along with marijuana, methamphetamine, and hallucinogens. Most other illicit drugs decreased slightly or remained unchanged.

Alcohol remains the most prevalent substance used by adolescents; alcohol prevalence rates among Hawaii students in 2003, however, are at record-low levels. Prevalence reports for cigarette use among Hawaii students started on a downward trajectory in 1998 and have continued on that course through 2003. Hawaii typically follows nationwide trends and 2003 is no exception. Prevalence rates in Hawaii for alcohol, tobacco, and illicit drugs, however, continue to be lower than nationwide prevalence rates.

The estimated number of adolescents needing treatment in the State of Hawaii has also been declining. On an equally encouraging note is the fact that more students in need of treatment are reporting that they have sought treatment from a treatment facility. Declining substance use rates and declining treatment needs can continue in the State of Hawaii as long as prevention efforts are directed at reducing elevated risk factors and promoting protective factors.

Underage Drinking. Alcohol is the number one drug of choice for America's young people. More than 10 million youth, ages 12 to 20, report drinking alcohol in the past month. The American Medical Association considers this an epidemic worth investing resources now, to prevent the costly social and physical consequences in the future.*

* Institute of Medicine, *Reducing Underage Drinking - A Collective Responsibility*, September 2003

National Statistics.

- 10.7 million underage youth drink, 7.2 million of whom are binge drinkers.
- Illegal alcohol consumption by underage youth account for up to $22 billion a year in sales.
- In a survey of Americans age 12-17, the average person took their first drink before age 13.
- Youth who use alcohol before 15 are four times more likely to be alcohol dependent than adults whose first drink is at the legal age of 21.
- The consequences of underage drinking are a tremendous expense to the U.S. economy and total more than $53 billion per year, by far the most costly of all drug problems.

Effects of underage drinking on health and safety

- Alcohol plays a key role in accidents, homicides and suicides, the leading causes of death among youth.
- Alcohol kills six times more young people than all illicit drugs combined.
- Alcohol is linked to as many as two-thirds of all sexual assaults and date rapes of teens and college students.
- Studies reveal that alcohol consumption by adolescents results in brain damage — possibly permanent — and impairs intellectual development.

Advertising.

- The alcohol industry spends approximately $4.8 billion every year on advertising, a powerful medium that has proven extremely persuasive to young people.
- A study of 12 year-olds found that children who were more aware of beer advertising held more favorable views on drinking and expressed an intention to drink more often as adults than did children who were less knowledgeable about the ads.
- A 1996 study of children ages nine to eleven found that children were more familiar with Budweiser's television frogs than Kellogg's Tony the Tiger, the Mighty Morphin' Power Rangers, or Smokey the Bear.
- A federally-funded study of 1,000 young people found that exposure to and liking of alcohol advertisements affects whether young people will drink alcohol.

Alcohol industry's role towards preventing underage drinking.

- The alcohol industry is a major obstacle to ending the epidemic of underage drinking. Prior to the release of the new report, the National Beer Wholesalers Association assailed it as a misuse of taxpayer dollars and lobbied Congress to undermine its importance.
- The Association also lobbied extensively to exclude alcohol messages from the government's billion dollar "Youth Anti-Drug Media Campaign," the largest taxpayer campaign to reduce youth substance abuse, despite the fact that alcohol is the number one drug of choice for youth.

Government prevent efforts to address underage drinking.

- The U.S. Surgeon General has never conducted a single workshop or report on underage drinking. Federal efforts to date to prevent and reduce underage drinking have been poorly funded, coordinated and promoted.
- The government is heavily lobbied by the alcohol industry, which donated more than $11.7 million to the national Democratic and Republican parties and their candidates in the 2000 election cycle, making it one of the most generous funders among major industries.

Changing the social environment.

- The alcohol industry has co-opted prevention efforts with their self-serving messages of moderation and personal responsibility.
- Traditional public health efforts to reduce underage drinking focus on youth education and prevention techniques, but research shows that this has had only limited success.
- Public health experts endorse expanding approaches that focus on how social environments actually encourage and enable alcohol abuse among youth. Environmental factors such as illegal alcohol sales to minors, alcohol distribution and pricing practices, cultural norms, marketing, promotions and advertising all create a culture where drinking is seen as sexy, cool, fun, cheap and easy to buy but also without consequence.

Findings.

- Patterns and consequences of underage drinking are closely related to the overall extent and patterns of drinking in society and are affected by the same factors that affect adult consumption.
- Underage drinking cannot be successfully addressed by focusing on youth alone. Efforts to reduce and prevent underage drinking need to focus on parents and other adults and include strategies that engage the society at large.
- Alcoholic beverages are far cheaper today than they were in the 1960s and 1970s.

Recommendations.

- Multiple components must be implemented that include science-based programs, research and evaluation.
- Congress and state legislators should raise alcohol taxes. Top priority should be given to raising beer taxes, and excise taxes on all alcoholic beverages should be indexed to the consumer price index to keep pace with inflation.
- Public and private funders should support community mobilization to reduce underage drinking. Community leaders should assess their local underage drinking problem and consider effective approaches such as community organizing, coalition building and strategic use of mass media.
- Residential colleges and universities should adopt comprehensive prevention approaches including environmental changes that limit underage access to alcohol.

- Local police, working with community leaders should adopt and announce policies for deterring and terminating underage drinking parties.
- States and communities should implement enforcement programs to deter adults from purchasing alcohol for minors.

Co-Occurring Disorder[†] State Infrastructure Grant (COSIG). The **C**o-**O**ccurring Disorder **S**tate **I**nfrastructure **G**rant (COSIG) provides funding to the States to develop or enhance their infrastructure to increase their capacity to provide accessible, effective, comprehensive, coordinated/integrated, and evidence-based treatment services to persons with co-occurring substance abuse and mental disorders. COSIG also provides an opportunity to participate in an evaluation of the feasibility, validity and reliability of the proposed co-occurring performance measures for the future Performance Partnership Grants (PPGs), and to participate in a national evaluation of the COSIG program.

In September 2003, the U.S. Department of Health and Human Services awarded Hawaii $3.6 million over five years to increase the capacity of state treatment systems to provide effective, coordinated and integrated treatment services to persons with co-occurring substance abuse and mental health disorders.

Hawaii was one of seven new grants awarded to stimulate states to provide comprehensive, evidence-based treatment to persons who have at least one mental disorder as well as an alcohol or drug use disorder. The Hawaii grant is managed through the Office of the Governor, with active participation of the state's lieutenant governor, who is co-chair of the project's coordinating committee. The program, envisioned to enhance the capacity and infrastructure available to provide integrated, evidence-based treatment services to people with co-occurring substance use and mental health disorders, is a collaboration among Hawaii's Department of Health, Department of Human Services and Department of Public Safety. The goal is to create a seamless and comprehensive system of care for people who have co-occurring disorders.

The three main goals of the Hawaii COSIG are to: establish a system-spanning task force, conduct a services pilot project, and develop a continuous quality improvement framework.

The COSIG program has two phases:

Phase I. The first three years of the grant focus on infrastructure development/enhancement.

[†] *Co-occurring disorders* refers to co-occurring substance use (abuse or dependence) and mental disorders. Clients said to have co-occurring disorders have one or more disorders relating to the use of alcohol and/or other drugs of abuse as well as one or more mental disorders. A diagnosis of co-occurring disorders (COD) occurs when at least one disorder of each type can be established independent of the other and is not simply a cluster of symptoms resulting from the one disorder. Many may think of the typical person with COD as having a severe mental disorder combined with a severe substance use disorder, such as schizophrenia combined with alcohol dependence. However, counselors working in addiction agencies are more likely to see persons with severe addiction combined with mild- to moderate-severity mental disorders; an example would be a person with alcohol dependence combined with a depressive disorder or an anxiety disorder. Efforts to provide treatment that will meet the unique needs of people with COD have gained momentum over the past 2 decades in both substance abuse treatment and mental health services settings.

Phase II. An additional 2 years of funding is provided at a lower level for evaluation and continued collection/reporting of performance data.

States have flexibility in identifying specific infrastructure development and enhancement activities that support the goals selected and respond to the needs and priorities identified by the State. However, the experience of other States suggests that certain areas of infrastructure development (e.g., standardized screening and assessment, complementary licensure and credentialing requirements, service coordination and network building, financial planning, and information sharing) reflect critical pathways for establishing complementary service delivery capacity in substance abuse and mental health service systems.

All awardees use the co-occurring performance measures adopted by National Association of State Alcohol and Drug Abuse Directors (NASADAD), and the National Association of State Mental Health Program Directors (NASMHPD), in conjunction with SAMHSA, to monitor the growth of their service capacity for treating persons with co-occurring disorders. Costs for collecting and reporting data on these measures were included in the proposed budget for the COSIG. The co-occurring performance measures are as follows:

- Percentage of adult clients in mental health and substance abuse programs with symptoms of the corresponding co-occurring problem;

- Percent of treatment programs that:
  - Screen for co-occurring disorders;
  - Assess for co-occurring disorders;
  - Provide treatment to clients through collaborative, consultative and integrated models of care;

- Percentage of clients who experience reduced impairment from their co-occurring disorders following treatment.

These measures are used by all COSIG awardees. The terms and conditions of the grant award also specify the data to be submitted to SAMHSA and the schedule for submission. Grantees are required to adhere to these terms and conditions of award.

Grantees must evaluate their projects in accordance with evaluation plans submitted with the grant application. Evaluations are designed to provide regular feedback to the project to improve services. The evaluation includes both process and outcome components. Process and outcome evaluations must measure change relating to project goals and objectives over time compared to baseline information. Control or comparison groups are not required.

If the project includes an implementation pilot involving services delivery, the evaluation includes client and system outcomes. No more than 20% of the total grant award may be used for evaluation and data collection.

Substance Abuse Treatment Services. Substance abuse treatment services include a continuum of services such as residential, day, intensive outpatient, and outpatient treatment modalities.

Residential programs provide a planned regimen of professionally directed evaluation, treatment, case management, and other ancillary and special services. Observation, monitoring, and treatment are available twenty-four (24) hours a day, seven (7) days a week.

Day treatment programs provide a planned regimen of comprehensive outpatient treatment including professionally directed evaluation, treatment, case management, and other ancillary and special services. This level of care provides the client with the opportunity to participate in a structured therapeutic program while being able to remain in the community.

Intensive outpatient programs provide non-residential intensive specialized services on a scheduled basis for individuals with substance abuse problems. Professionally directed evaluation, treatment, case management, and recovery services are provided.

Outpatient programs provide non-residential comprehensive specialized services on a scheduled basis for individuals with substance abuse problems. Professionally directed evaluation, treatment, case management, and recovery services shall be provided to clients with less problematic substance abuse related behavior than would be found in a residential or day treatment program.

Transitional therapeutic living programs provide a structured residential living environment to clients who are receiving substance abuse treatment in intensive outpatient or outpatient treatment services, or who have been clinically discharged within six (6) months from a substance abuse treatment program. Programs provide the necessary support and encouragement so that clients can complete treatment, adjust to a chemically abstinent lifestyle, and manage activities of daily living so that they can move towards independent housing and life management.

Treatment activities. Individual sessions may include the following:

Screening. The process by which the client is determined to be appropriate and eligible for admission. The determination of a particular client's appropriateness for a program requires the counselor's judgment and skill and is influenced by the program's environment and modality, as well as the use of established patient placement criteria.

Assessment. The process by which a counselor/program identifies and evaluates an individual's strengths, weaknesses, problems and needs for the development of a treatment plan. Although assessment is a continuing process, it is generally emphasized early in treatment. The counselor evaluates major life areas (e.g., physical health, vocational development, social adaptation, legal involvement and psychological functioning) and assesses the extent to which alcohol or drug use has interfered with the client's functioning in each of these areas. The result of this assessment should suggest the focus of treatment.

Treatment planning. Treatment planning is the process by which the counselor and the client identify and rank problems needing resolution, establish agreed upon immediate and long-term goals, and decide upon a treatment process and the resources to be utilized.

Individual counseling. Utilization of special skills to assist individuals in achieving objectives through exploration of a problem and its ramifications, examination of attitudes and feelings, consideration of alternative solutions, and decision-making.

Group Sessions. Group sessions may include the following:

Process groups involve the utilization of special skills to assist groups in achieving objectives through the exploration of a problem and its ramifications, examination of attitudes and feelings, consideration of alternative solutions, and decision-making.

Task groups are similar to process groups, however, these groups tend to be more highly structured, with the counselor having an explicit agenda and objectives for each group.

Education groups have as their primary objective the provision of information by the counselor concerning alcohol and other drugs and available services and resources. These groups tend to be didactic with a specified curriculum as the foundation for the session.

Skill building groups teach clients through demonstrations and practice how to do something that requires a skill. The skills taught can be divided into either daily living skills (e.g., managing money, food preparation, accessing information directories), or inter-personal skills (e.g., affective assertiveness, stress management, ability to give positive reinforcement).

Recreational groups involve the client in learning leisure-time activities.

Family counseling is the utilization of special skills to assist families in achieving objectives through the exploration of a problem and its ramifications, examination of attitudes and feelings, consideration of alternative solutions, and decision-making. Behavioral, cognitive, interpersonal strategies/approaches may be used. The "family" may involve parents, children, partners or other significant others within the client's home environment who will have a major role to play in the client's recovery, e.g., aunts, foster parents, boarding home operators.

Prescription Drug Abuse.† Prescription medications such as pain relievers, tranquilizers, stimulants, and sedatives are very useful treatment tools but sometimes people do not take them as directed and may become addicted. Pain relievers make surgery possible, and enable many individuals with chronic pain to lead productive lives. Most people who take prescription medications use them responsibly. However, the inappropriate or nonmedical use of prescription medications is a serious public health concern. Nonmedical use of prescription medications like

† National Institute on Drug Abuse (NIDA) – revised February 2005.

opioids, central nervous system (CNS) depressants, and stimulants can lead to addiction, characterized by compulsive drug seeking and use.

Patients, healthcare professionals, and pharmacists all have roles in preventing misuse and addiction to prescription medications. For example, when a doctor prescribes a pain relief medication, CNS depressant, or stimulant, the patient should follow the directions for use carefully, learn what effects the medication could have, and determine any potential interactions with other medications. The patient should read all information provided by the pharmacist. Physicians and other healthcare providers should screen for any type of substance abuse during routine history-taking, with questions about which prescriptions and over-the-counter medicines the patient is taking and why. Providers should note any rapid increases in the amount of a medication needed or frequent requests for refills before the quantity prescribed should have been used, as these may be indicators of abuse.

Commonly Abused Prescription Medications. While many prescription medications can be abused or misused, these three classes are most commonly abused:

Opioids - often prescribed to treat pain.
CNS Depressants - used to treat anxiety and sleep disorders.
Stimulants - prescribed to treat narcolepsy and attention deficit/hyperactivity disorder.

Opioids. Opioids are commonly prescribed because of their effective analgesic, or pain relieving, properties. Studies have shown that properly managed medical use of opioid analgesic compounds is safe and rarely causes addiction. Taken exactly as prescribed, opioids can be used to manage pain effectively.

Among the compounds that fall within this class—sometimes referred to as narcotics—are morphine, codeine, and related medications. Morphine is often used before or after surgery to alleviate severe pain. Codeine is used for milder pain. Other examples of opioids that can be prescribed to alleviate pain include oxycodone (OxyContin—an oral, controlled release form of the drug); propoxyphene (Darvon); hydrocodone (Vicodin); hydromorphone (Dilaudid); and meperidine (Demerol), which is used less often because of side effects. In addition to their effective pain relieving properties, some of these medications can be used to relieve severe diarrhea (Lomotil, for example, which is diphenoxylate) or severe coughs (codeine).

Opioids act by attaching to specific proteins called opioid receptors, which are found in the brain, spinal cord, and gastrointestinal tract. When these compounds attach to certain opioid receptors in the brain and spinal cord, they can effectively change the way a person experiences pain.

In addition, opioid medications can affect regions of the brain that mediate what we perceive as pleasure, resulting in the initial euphoria that many opioids produce. They can also produce drowsiness, cause constipation, and, depending upon the amount taken, depress breathing. Taking a large single dose could cause severe respiratory depression or death.

Opioids may interact with other medications and are only safe to use with other medications under a physician's supervision. Typically, they should not be used with substances such as

alcohol, antihistamines, barbiturates, or benzodiazepines. Since these substances slow breathing, their combined effects could lead to life-threatening respiratory depression.

Long-term use also can lead to physical dependence—the body adapts to the presence of the substance and withdrawal symptoms occur if use is reduced abruptly. This can also include tolerance, which means that higher doses of a medication must be taken to obtain the same initial effects. Note that physical dependence is not the same as addiction—physical dependence can occur even with appropriate long-term use of opioid and other medications. Addiction, as noted earlier, is defined as compulsive, often uncontrollable drug use in spite of negative consequences.

Individuals taking prescribed opioid medications should not only be given these medications under appropriate medical supervision, but also should be medically supervised when stopping use in order to reduce or avoid withdrawal symptoms. Symptoms of withdrawal can include restlessness, muscle and bone pain, insomnia, diarrhea, vomiting, cold flashes with goose bumps ("cold turkey"), and involuntary leg movements.

Individuals who become addicted to prescription medications can be treated. Options for effectively treating addiction to prescription opioids are drawn from research on treating heroin addiction. Some pharmacological examples of available treatments follow:

Methadone, a synthetic opioid that blocks the effects of heroin and other opioids, eliminates withdrawal symptoms and relieves craving. It has been used for over 30 years to successfully treat people addicted to opioids.

Buprenorphine, another synthetic opioid, is a recent addition to the arsenal of medications for treating addiction to heroin and other opiates.

Naltrexone is a long-acting opioid blocker often used with highly motivated individuals in treatment programs promoting complete abstinence. Naltrexone also is used to prevent relapse.

Naloxone counteracts the effects of opioids and is used to treat overdoses.

Central Nervous System (CNS) Depressants. CNS depressants slow normal brain function. In higher doses, some CNS depressants can become general anesthetics. Tranquilizers and sedatives are examples of CNS depressants.

CNS depressants can be divided into two groups, based on their chemistry and pharmacology:

Barbiturates, such as mephobarbital (Mebaral) and pentobarbitalsodium (Nembutal), which are used to treat anxiety, tension, and sleep disorders.

Benzodiazepines, such as diazepam (Valium), chlordiazepoxide HCl (Librium), and alprazolam (Xanax), which can be prescribed to treat anxiety, acute stress reactions, and panic attacks. Benzodiazepines that have a more sedating effect, such as estazolam (ProSom), can be prescribed for short-term treatment of sleep disorders.

There are many CNS depressants, and most act on the brain similarly—they affect the neurotransmitter gamma-aminobutyric acid (GABA). Neurotransmitters are brain chemicals that facilitate communication between brain cells. GABA works by decreasing brain activity. Although different classes of CNS depressants work in unique ways, ultimately it is their ability to increase GABA activity that produces a drowsy or calming effect. Despite these beneficial effects for people suffering from anxiety or sleep disorders, barbiturates and benzodiazepines can be addictive and should be used only as prescribed.

CNS depressants should not be combined with any medication or substance that causes sleepiness, including prescription pain medicines, certain over-the-counter cold and allergy medications, or alcohol. If combined, they can slow breathing, or slow both the heart and respiration, which can be fatal.

Discontinuing prolonged use of high doses of CNS depressants can lead to withdrawal. Because they work by slowing the brain's activity, a potential consequence of abuse is that when one stops taking a CNS depressant, the brain's activity can rebound to the point that seizures can occur. Someone thinking about ending their use of a CNS depressant, or who has stopped and is suffering withdrawal, should speak with a physician and seek medical treatment.

In addition to medical supervision, counseling in an in-patient or out-patient setting can help people who are overcoming addiction to CNS depressants. For example, cognitive-behavioral therapy has been used successfully to help individuals in treatment for abuse of benzodiazepines. This type of therapy focuses on modifying a patient's thinking, expectations, and behaviors while simultaneously increasing their skills for coping with various life stressors.

Often the abuse of CNS depressants occurs in conjunction with the abuse of another substance or drug, such as alcohol or cocaine. In these cases of polydrug abuse, the treatment approach should address the multiple addictions.

Stimulants. Stimulants increase alertness, attention, and energy, which are accompanied by increases in blood pressure, heart rate, and respiration.

Historically, stimulants were used to treat asthma and other respiratory problems, obesity, neurological disorders, and a variety of other ailments. As their potential for abuse and addiction became apparent, the use of stimulants began to wane. Now, stimulants are prescribed for treating only a few health conditions, including narcolepsy, attention-deficit hyperactivity disorder (ADHD), and depression that has not responded to other treatments. Stimulants may also be used for short-term treatment of obesity and for patients with asthma.

Stimulants such as dextroamphetamine (Dexedrine) and methylphenidate (Ritalin) have chemical structures that are similar to key brain neurotransmitters called monoamines, which include norepinephrine and dopamine. Stimulants increase the levels of these chemicals in the brain and body. This, in turn, increases blood pressure and heart rate, constricts blood vessels, increases blood glucose, and opens up the pathways of the respiratory system. In addition, the increase in dopamine is associated with a sense of euphoria that can accompany the use of stimulants.

Research indicates that people with ADHD do not become addicted to stimulant medications, such as Ritalin, when taken in the form and dosage prescribed. However, when misused, stimulants can be addictive.

The consequences of stimulant abuse can be extremely dangerous. Taking high doses of a stimulant can result in an irregular heartbeat, dangerously high body temperatures, and/or the potential for cardiovascular failure or seizures. Taking high doses of some stimulants repeatedly over a short period of time can lead to hostility or feelings of paranoia in some individuals.

Stimulants should not be mixed with antidepressants or over-the-counter cold medicines containing decongestants. Antidepressants may enhance the effects of a stimulant, and stimulants in combination with decongestants may cause blood pressure to become dangerously high or lead to irregular heart rhythms.

Treatment of addiction to prescription stimulants, such as methylphenidate and amphetamines, is based on behavioral therapies proven effective for treating cocaine or methamphetamine addiction. At this time, there are no proven medications for the treatment of stimulant addiction. Antidepressants, however, may be used to manage the symptoms of depression that can accompany early abstinence from stimulants.

Depending on the patient's situation, the first step in treating prescription stimulant addiction may be to slowly decrease the drug's dose and attempt to treat withdrawal symptoms. This process of detoxification could then be followed with one of many behavioral therapies. Contingency management, for example, improves treatment outcomes by enabling patients to earn vouchers for drug-free urine tests; the vouchers can be exchanged for items that promote healthy living. Cognitive-behavioral therapies, which teach patients skills to recognize risky situations, avoid drug use, and cope more effectively with problems, are proving beneficial. Recovery support groups may also be effective in conjunction with a behavioral therapy.

HAWAII DRUG CONTROL PLAN

The Hawaii Drug Control Plan† details the goals and key strategies that will be carried forth in 2005-2006. Strategies contained in the Hawaii Drug Control Plan are reflective of the input gathered from community representatives and experts in the field who participated in the action planning process. Recommendations from the Report of the Hawaii Drug Control Action Working Group have been incorporated into the Hawaii Drug Control Plan.

The three strategies of the Hawaii Drug Control Plan are:

> To prevent illicit drug use and underage drinking before it starts. "Our Keiki Are Our Future."
>
> To provide a continuum of treatment options for illicit drug and underage alcohol users. "Hoʻi hou ka iwi kuamoʻo - Return to the Family" and "Access to Treatment."

† Hawaii Drug Control Plan, January 18, 2005.

To disrupt the distribution of illicit drugs by expanding law enforcement abilities and to enhance interagency and community cooperation and collaboration. "Making Our Community Safe."

Overarching themes. The overarching theme for the Hawaii Drug Control Plan is "Changing Attitudes, Changing Lives: A Life in the Community For Everyone." Woven into the fabric of this theme are the elements of coordination, effectiveness, and facilitation of information. These elements allow for an orderly and consistent approach to the Hawaii Drug Control Plan through community based input and participation.

Coordination. As recommended in the 2003 Hawaii Drug Control Strategy Summit, the Drug Control Liaison position was established to facilitate systems change, to provide statewide coordination of underage drinking and drug control efforts, and to ensure that public funds are utilized effectively.

Effectiveness. The Drug Control Liaison and State Coordinating Council shall focus on minimizing duplicative efforts throughout all layers of government while promoting coordination and identifying gaps in services to maximize effectiveness throughout the State.

Information dissemination. Currently, there is an absence of a comprehensive and integrated data infrastructure, data reporting methods, and data collection within State agencies. Logic dictates that a better informed community contributes to informed policy and informed resource allocation. Thus, it is necessary to create an appropriate data information system to disseminate findings and develop priorities for funding.

Three-prong approach. Utilizing the overarching themes of coordination, effectiveness, and facilitation of information, the Hawaii Drug Control Plan focuses on a three-prong approach to address illicit drug use and underage drinking. This approach focuses on prevention, treatment, and law enforcement.

Prevention. The primary focus of the prevention efforts will be to target middle school youth and to develop effective after school programs. Federal funds have been secured for the expansion of prevention programs at existing youth centers. An increased number of age appropriate prevention programs will be available throughout the State to reduce teen experimentation with drugs and alcohol.

Reducing underage drinking is a high priority for this Administration. Alcohol is the number one drug of choice for teens in Hawaii, as well as throughout the nation. Commonly recognized as a gateway drug, the continued use of alcohol often leads to illicit drug use. The State will take a proactive stand in reducing underage drinking and partner with existing organizations and other public agencies to reduce duplicative efforts, maximize limited resources, and coordinate new and innovative strategies.

Treatment. The primary focus of treatment efforts will be to enhance the current treatment system of care and develop a resource structure that is adequate to support the full continuum of care, which includes outreach engagement and stabilization, as well as relapse prevention services.

Law Enforcement. The primary focus of law enforcement efforts will be to make communities safer through a number of legislative initiatives to be introduced during the 2005 legislative session. In cooperation with the law enforcement community, increased focus will be placed on identifying drug dealers and ridding communities of drug use, manufacturing, and distribution.

Summary. The Hawaii Drug Control Plan will be the driving force to provide clear direction and common ground for future endeavors addressing illicit drug use and underage drinking in the State of Hawaii.

The State Coordinating Council will utilize one voice to reduce the negative impact of illicit drug use and underage drinking. The Council will focus on needs of communities, while promoting collaborative partnerships between federal, state, and county governments as well as communities. The focus will be to eliminate duplication and the fragmentation of services and to encourage more responsible use of our limited resources.

A centralized data center and a website to disseminate substance abuse information to the public are critical elements in the Hawaii Drug Control Plan. Additional Federal resources will be aggressively pursued for law enforcement, community development, and prevention and treatment programs. Communities will be empowered to stand up, take control of their community and fight the problem of drug use and underage drinking one block, one home at a time.

The Hawaii Drug Control Plan will serve as the blueprint for change in building healthier communities and healthier families in the State of Hawaii.

RECOMMENDATIONS

Based on deliberations, as well as presentations throughout the past year, HACDACS recommendations to address the issue of substance abuse are as follows:

HACDACS recommends focusing on communities' needs to reduce the impact of illicit drug use and underage drinking.

HACDACS recommends supporting and empowering communities to address illicit drug use and underage drinking.

HACDACS recommends supporting efforts that ensure accountability throughout the substance abuse prevention and treatment systems to ensure that public funds are utilized effectively.

HACDACS recommends expanding coordination between agencies and organizations to include collaboration that encourages community participation.

HACDACS recommends creating an integrated data infrastructure to inform decision-making, prioritizing of services and resource allocation.

HACDACS recommends reducing underage drinking through partnerships between organizations and public agencies to coordinate new and innovative strategies.

HACDACS recommends enhancing the continuum of care that supports the continuum of care, including outreach, stabilization, as well as relapse prevention services.

As stated in §329-4, HRS, the duties of the Hawaii Advisory Commission on Drug Abuse and Controlled Substances (HACDACS) are to:

(1) Act in an advisory capacity to the department relating to the scheduling of substances provided in part II of this chapter, by recommending the addition, deletion, or rescheduling of all substances enumerated in part II of this chapter.

(2) Act in an advisory capacity to the department relating to establishment and maintenance of the classes of controlled substances, as provided in part II of this chapter.

(3) Assist the department in coordinating all action programs of community agencies (state, county, military, or private) specifically focused on the problem of drug abuse.

(4) Assist the department in carrying out educational programs designed to prevent and deter abuse of controlled substances.

(5) Encourage research on abuse of controlled substances. In connection with such research, and in furtherance of the enforcement of this chapter, it may, with the approval of the director of health:

(A) Establish methods to assess accurately the effects of controlled substances and to identify and characterize controlled substances with potential for abuse;

(B) Make studies and undertake programs of research to:

(i) Develop new or improved approaches, techniques, systems, equipment, and devices to strengthen the enforcement of this chapter;

(ii) Determine patterns of abuse of controlled substances and the social effects thereof; and

(iii) Improve methods for preventing, predicting, understanding, and dealing with the abuse of controlled substances.

(6) Create public awareness and understanding of the problems of drug abuse.

(7) Sit in an advisory capacity to the governor and other state departments as may be appropriate on matters relating to the commission's work.

(8) Act in an advisory capacity to the director of health in substance abuse matters under chapter 321, part XVI. For the purposes of this paragraph, "substance" shall include alcohol in addition to any drug on schedules I through IV of this chapter and any substance which includes in its composition volatile organic solvents.